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DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
XXXX Injection XX XX X 1

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: Orthopaedic Surgery

REVIEW OUTCOME: Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

☐ Overturned	Disagree
☐ Partially Overturned	Agree in part/Disagree in part
☒ Upheld	Agree

PATIENT CLINICAL HISTORY [SUMMARY]: XXXX, when XXXX began having XX XX XX XX and pain. XXXX was diagnosed with medial XX, XX XX (XX.XX), and pain in XX XX (XX.XX). XXXX for acute onset of XX XX pain secondary to XXXX work-related injury on XXXX. XXXX reported the pain was XX. Aggravating factors included physical activity and any movement. The pain was relieved by rest, ice, medication, and modification of activity. The symptoms had been associated with XX. The XX pain was preceded by unusual activity. XXXX had been seen in the emergency room on XXXX and referred to XXXX. There was no previous XX therapy performed and no previous surgeries. Evaluation of the XX XX was significant for notable tenderness of XX XX XX and positive resisted XX pronation. There was grossly normal sensation in the XX, XX, and XX. Treatment options included injection of XXXX or XX XX, stretching exercises, and activity modification. XXXX noted that XXXX might require multiple injections over a XX- to XX-month period and planned to pre-certify the XX XX XX origin XXXX injection. XXXX restricted XXXX from XX greater than XX pounds with the XX XX. On XXXX, XXXX stated XXXX had attended XX therapy XX times a week for XX weeks. XXXX also mentioned that "the XX therapy was helping but the pain is still there, just not as XX." XXXX described the XX XX pain as "XX." On examination, there was slight XX of the XX XX XX origin. XXXX noted that XXXX had persistent symptoms after completing XX therapy. Therefore, XXXX's office would attempt to pre-certify the XXXX injection through the XX. An x-ray of the XX dated XXXX showed no acute bone or joint abnormalities. The treatment to date included rest (helpful), ice (helpful), medications including XXXX (helpful), a XX, XX therapy (slightly helpful), and modification of activity (helpful). Per a utilization review decision letter dated XXXX, the requested service of XXXX injection to the XX XX x1, initial, with ultrasound guidance was denied by XXXX. Rationale: "Based upon the medical

documentation presently available for review, Official Disability Guidelines would not support a medical necessity for this specific request. As a general rule, this reference does not support a medical necessity for the requested injection as it relates to the described medical situation. Additionally, there is no documentation to indicate that there has been a previous attempt at treatment in the form of XX therapy services. With such documentation, presently, the above-noted reference would not support a medical necessity for this specific request as submitted." Per a reconsideration review decision letter dated XXXX, the prior denial was upheld by XXXX with the following rationale: "This is a noncertification of a request for reconsideration of a XXXX injection to the XX XX. The previous noncertification on XXXX, was due to lack of medical necessity and lack of failure of lower levels of care. The previous noncertification is supported. Additional records were not submitted for review. XXXX injections are not routinely recommended for XX. Long-term outcomes are poor. There is no objective documentation of activity modification, failure of XX medication, or formal XX therapy to support the request. The request for reconsideration of a XXXX injection to the XX XX is not certified."

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION: The documentation provided indicates the injured worker has ongoing XX XX pain and a diagnosis of XX XX that has failed to improve with rest, ice, XX, XX, activity modification, and XX therapy. The provider has recommended a XX injection. The XX injection was previously denied due to lack of documentation of a failure of lower levels of care as well as the fact that XX injections are not recommended by the ODG for XX. The current documentation indicates that the injured worker has failed to improve with XX weeks of XX therapy, and the provider again recommends a XX injection. XX therapy progress notes are included. While the ODG does not generally recommend XX injections for the treatment of XX, the ODG supports occasional approval for a one-time injection when there has been a failure of conservative treatment. Conservative treatment includes XX and XX injections as well as, XX, activity modification, XX, and XX therapy. The documentation does not indicate a trial and failure of XX or XX injection. As such, the prior denial should be upheld as XX injections are not recommended by the ODG, and there is no documented trial and failure of all conservative modalities. Given the documentation available, the requested service(s) is considered not medically necessary and the request is upheld.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

☒ MEDICAL JUDGMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

☒ ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

ODG, XX: XX XX injections